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Advance healthcare directives in mental health: A qualitative analysis from a Spanish healthcare professional's viewpoint

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Accessible summary

What is known on the subject?

- Advance care planning (ACP) in mental health is a useful tool to avoid human rights violations in mental health settings. However, ACP is not yet a reality in the Spanish context.
- The advance healthcare directive (AHD) is a document reflecting healthcare preferences, drafted within the framework of the ACP process, to be applied in situations in which an individual's legal capacity may be questionable.
- No study has explored the viewpoint of Spanish mental healthcare professionals towards AHDs in the mental health field. Considering their extensive use, further study of providers' knowledge and attitudes is warranted.

What does the paper add to existing knowledge?

- The study adds knowledge about the viewpoint of Spanish mental healthcare professionals towards the implementation of AHDs in their clinical practices.
- This study illuminates the prevailing paternalistic provider–user relationship as the main barrier surrounding AHD management in terms of decision-making.
- Our findings support the need for broader awareness, staff training regarding the documentation, the conversation process and communication skills, and personalized assistance in the mental health services to implement AHDs in everyday practice.

What are the implications for practice?

- Advance healthcare directives are a recovery tool that offers major information regarding mental health user preferences. Although they pose challenges for clinical practice, AHDs should be incorporated into interventional mental health care.
- Obtaining up-to-date perspectives held by mental healthcare professionals regarding AHDs allows the administration to determine the aspects requiring reinforcement.
- The implementation of AHDs in the Spanish mental health system requires macro- and micro-changes, both ethically and structurally, so that mental healthcare

professionals relinquish their paternalistic approach and embrace new ways of relating to users.

Abstract

Introduction: An advance healthcare directive (AHD) is a written document that contains a patient-in-care's will and preferences concerning the treatment options available to them, should they lack decision-making capacity. AHDs are completed within a broader framework known as advance care planning. No study has explored the viewpoint of Spanish mental healthcare professionals towards AHDs.

Aim: To explore the viewpoint of mental health professionals towards the implementation of AHDs in mental health.

Method: A qualitative study was conducted using semi-structured interviews that were thematically analysed.

Findings: Three main themes were identified: care planning culture; barriers for the practical management of AHDs; and reasons to not honour patient-in-care AHDs.

Discussion: Professionals find it pragmatically difficult to stop applying traditional paternalistic practices. To implement AHDs, improving the knowledge and awareness of AHDs and management of non-technical skills through training is required. Such training should include users and families and allow for compliance with United Nations requirements.

Implications for practice: Advance healthcare directives offer important information regarding user preferences, although they pose challenges for practices. Acquiring an up-to-date perspective on the attitudes of professionals towards AHDs allows organizations to attend to particular aspects that require reinforcement. Wider awareness, staff training and new ways of relating to users are necessary to implement AHDs in Spanish context.

Relevance statement: A better understanding of the attitudes of Spanish mental health professionals towards AHDs was achieved. Despite the implementation of AHDs being an important and potentially beneficial initiative, mental health professionals find many pragmatic issues that need addressing before AHDs become a reality in their clinical practice. Wider awareness, staff training, personalized assistance and new ways of relating to users are required to implement AHDs in everyday practice.

KEYWORDS

advance directives, living wills, mental health, mental illness, nursing, professionals

1 | INTRODUCTION

The prevailing mental healthcare model through to the late 20th century was based on the paternalistic approach of mental healthcare professionals towards their patients. It has now progressed to favour freely expressed patient opinion (Stein & Giordano, 2015). This change in the healthcare paradigm was driven by the approval of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (UN, 2006), which underlines the right, among others, to individual autonomy, to information and participation in clinical decision-making, by those who ultimately should be actively involved in processes affecting their own health (Hamann et al., 2011).

Since then, a range of international reports (UN, 2014 ; WHO, 2012) has identified cases of human rights violations in mental health contexts, involving inappropriate practices by institutions and professionals. These cases are related to a lack of recognition of legal status, safety, respect for privacy, protection from degrading treatment, freedom of speech and opinion, access to information and finally to healthcare (Suess Schwend et al., 2016). Consequently, the Council of Europe recommended member states modify their policies regarding bioethics and legislation in the mental health field (Council of Europe, 2009; European Parliament, 2017) to include active participation in decision-making processes and to regulate advance healthcare directives (Slade, 2017) in line with Article 12

of the CRPD. Member states were also recommended to align their legislation accordingly and to provide appropriate measures for supported decision-making and AHDs (Gieselmann, Simon, Vollmann, & Schöne-Seifert, 2018).

The AHD is a tool to be used as part of the caring and therapeutic process, within the framework of a broader concept known as advance care planning (ACP). ACP is defined as a process that supports people-in-care, through understanding and sharing their personal values, life goals and preferences regarding future medical care when they may be unable to make clear decisions due to altered levels of consciousness and incapacitating severe illness (Sudore et al., 2017).

Although AHDs are not generally legally binding documents (Duffy & Kelly, 2019; National Gold Standards Framework Centre, 2019; Sudore et al., 2017), they are important and should be considered in the decision-making processes. They contain the will and preferences of persons-in-care, particularly concerning treatment decisions that may arise that will affect them directly although they temporarily lack the capacity (construed functionally) at a time when making or communicating a decision is required (Kelly, 2017). The AHD content, open and flexible, enables their preferences regarding crisis intervention, treatments and clinical procedures to reduce or improve symptoms to be registered, all within a framework of good healthcare practice. Likewise, they allow legal representatives to be identified and registered for cases where legal capacity may be questionable and/or who to notify regarding the administration of finances and guardianship of people and/or pets who may be dependent on them (Srebnik et al., 2005).

Although the only systematic review carried out using AHD in mental health does not establish specific recommendations derived from insufficient evidence in this regard (Campbell & Kisely, 2009), in the last decade, seemingly promising benefits of AHDs as a recovery tool have been described by international studies. The main benefits identified are as follows: improved adherence to prescribed medication, reduced crisis symptom severity and coercive interventions, greater satisfaction regarding treatment, earlier recovery and improved therapeutic relationships with mental healthcare professionals (Easter, Swanson, Robertson, Moser, & Swartz, 2017; Tekkalaki et al., 2018). Additionally, the prevention of the risk of self-harm and violence towards others is pointed out, as well as a reduction in nights in prison and contacts with the judicial system (Suess Schwend et al., 2016).

Controversy exists regarding the capacity of mental health service users to make decisions independently. It has been discussed that a lack of decision-making capacity should be a necessary criterion for involuntary treatment in psychiatric care, similar to that in somatic care. Laws on involuntary psychiatric treatment focus on the presence of severe mental illness, need of treatment or danger to self or others but not on the patient's ability to make autonomous decisions (Sjöstrand et al., 2015). Certain critics of the implementation of AHDs in mental health uphold that users may cause themselves harm if their legal right to make a "bad decision" were honoured (Cave, 2017).

In Spain, AHD regulating policies arose with the creation of Law 41/2002, of the 14 November, governing patient autonomy and rights—for instance, the obligation to inform and right to clinical documentation. Subsequently, the Royal Decree 124/2007, of the 2 February regulating the National Registry of Advance Directives, was published. However, none of the aforementioned regulations contemplated the use of AHDs in mental health, thus revealing a legal void. Likewise, no research in the Spanish mental health context was found, although it involved other sectors such as primary and emergency care (Mateos Rodríguez, Huerta Arroyo, & Benito Vellisca, 2007), in which the degree of acceptance of such documents by professionals was explored.

1.1 | Rationale

Decision-making in mental health care involves providers and users working together. The implementation of AHDs in mental health lags far behind user interest, despite United Nations requirements, and raising awareness by advocacy groups (Easter et al., 2017). Although international evidence has identified AHDs as a decision support tool, and recommendations have been made in mental health at the policy level, implementation remains limited due to ethical and clinical issues (Slade, 2017; Suess Schwend et al., 2016).

The ethical justification is that AHD is a right, but providers need to balance the bioethical principles of autonomy and justice with beneficence and non-maleficence. The clinical justification is that AHD leads to improved outcome, yet the available evidence base is inconclusive. Studies have been performed in different clinical and country settings on the issue of providers' attitude towards AHD, some descriptive nature, some using a mixed method and some qualitative (Coleman, 2012). Although various studies have shown a positive attitude of providers towards users' AHD, this does not necessarily translate into providers' adherence to users' AHD (Coleman, 2012). Similarly, Spanish healthcare professionals in the specialist, primary and palliative fields show a positive attitude towards users' AHD but are unaware of what an AHD comprises or how to complete one (Aguilar-Sánchez et al., 2018; Champer Blasco, Caritg Monfort, & Marquet Palomer, 2010; Fajardo, Valverde Bolívar, Jiménez Rodríguez, Gómez Calero, & Huertas Hernández, 2015; Toro, Silva Mato, Piga Rivero, & Alfonso Galán, 2013). Furthermore, no study has explored the viewpoint of Spanish mental healthcare professionals towards AHDs in the mental health field. Considering the extensive use of AHD in clinical practice, further study of providers' knowledge and attitudes towards AHD in mental health is warranted.

1.2 | Aim and objectives

To explore the viewpoint of Spanish mental healthcare professionals towards implementing AHDs in their clinical practice setting.

2 | METHODS

A phenomenological approach centred on the opinions of mental healthcare professionals was applied via semi-structured interviews

TABLE 1 Sample characteristics

Interview	Gender	Profession	Workplace	Length of service (years)
E01	Man	Psychologist	RSRC	11
E02	Woman	Psychologist	RSRC	10
E03	Woman	Psychologist	RSRC	5
E04	Woman	Nursing Assistant	PHU	7
E05	Woman	Nursing Assistant	PHU	12
E06	Man	Psychiatrist	PHU	18
E07	Woman	Psychiatrist	PHU	12
E08	Woman	Nurse	MHU	15
E09	Man	Psychiatrist	MHU	20
E10	Woman	Nurse	MHU	27
E11	Woman	Nurse	MHU	9

Abbreviations: MHU (adults), Mental Health Unit; PHU, Psychiatric Hospitalization Unit; RSRC, Rehabilitation and Social Reinsertion Centre.

(Giorgi, 2000; Paley & Husserl, 1997). This qualitative research methodology facilitates the understanding of behaviour in everyday contexts and exploration of individual perspectives, particularly the subjective understanding of complex concepts (Crowe, Inder, & Porter, 2015). Furthermore, an inductive approach was applied because of the observations and phenomena; in our case, the opinions of mental healthcare professionals towards AHD in Spain could generate new knowledge in this particular field (Woo, O'Boyle, & Spector, 2017). This manuscript follows the recommendations by the Consolidated Criteria for Reporting Qualitative Research (COREQ), a 32-item checklist for reporting interviews (Tong, Sainsbury, & Craig, 2007).

2.1 | Study sample

The study sample consisted of healthcare workers from the Province of Alicante (Spain) who worked at Mental Health Units (MHUs), Psychiatric Hospitalization Units (PHU) or Rehabilitation and Social Reinsertion Centres (RSRCs), with a length of service equalling five years or more in such units or services within the public sector. Selection was performed via a convenience, non-probabilistic sampling method while endeavouring to achieve representativeness for each clinical service. Potential participants were identified via key informants (nursing supervisors). Researchers then telephoned candidates explaining the study characteristics and inviting them to participate. All the candidates agreed to voluntarily participate in the study and signed informed consent.

Finally, 11 mental healthcare professionals participated, among whom were psychiatrists, nurses (specialist or otherwise), psychologists and nursing assistants. The participant characteristics are shown in Table 1.

2.2 | Data collection

Data collection was performed during November 2017. Appointments were made with those who agreed to participate. RJS and SGS carried out all interviews, which lasted approximately 50 min. Both RJS and SGS are female PhD nurses with previous experience conducting qualitative research. The semi-structured, face-to-face interviews were conducted at the healthcare centre of the interviewees' choice, in which an appropriately confidential atmosphere was created. Data collection stopped after 11 interviews because the researchers believed data saturation had been reached.

After providing introductory information regarding the interviewers' professional backgrounds and aims of the current study, the interviewees were questioned on their general occupational details (profession, workplace and length of service). The study's particular areas of interest were included in the formulation of eight open-ended questions based on the literature reviewed and specific aims of the project (Table 2). Notes were not taken. The interviews were recorded in a digital audio format to enable verbatim transcription. The latter was presented to the participants to corroborate their accuracy. All of them agreed on the transcript submitted, and no changes were made.

2.3 | Data analysis

The data were analysed following the 6-step thematic analysis framework by Braun and Clarke (2006). First, all interviews were heard and reheard at least one more time using a triangulation method. The repetitive reading of the resultant transcripts helped familiarize researchers with the data. Second, the authors identified an initial list of thematic codes, considering their frequency of occurrence. Third, via a dynamic process, the initial codes were classified into candidate themes and subthemes. Once the differences between the latter and those of the available literature and/or conceptual framework were identified, the team completed the fourth step by consensually refining the classification to which data were most relevant and provided significance to the themes and subthemes generated. For the fifth stage, the authors decanted more concise

TABLE 2 Main questions

What do you know about advanced care planning in mental health?
Have you (or your team) ever used it in the mental health field?
Whether you have used it or not, which healthcare resource should promote it? Which professional should be responsible for its completion?
Could you describe any positive or negative aspects related to the use of AHDs in clinical practice?
Could you explain any past experience in which it would have been useful for you, or mental health users, to have had an AHD?
Do you think that mental health users or their relatives know about AHDs?
How important are AHDs in a mental health user's life? Why?
What role does the family play in completing an AHD in the mental health field?

Abbreviation: AHD, advance healthcare directive.

names for the themes and subthemes. As a sixth and final step, the findings were reported in written form, including examples capturing the essence of the information being discussed. No software was used for qualitative analysis because the research team preferred to approach the analysis traditionally.

2.4 | Ethical considerations

All procedures in studies involving human participants were performed in accordance with the ethical standards of the institutional research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. All candidates were informed of the purpose of the study. Informed consent was obtained from all individuals included in the study. Additionally, authorization from the institutions where they worked was procured.

3 | FINDINGS

Three main themes were identified describing situations that arose frequently during the interviews with the mental healthcare professionals (Table 3):

3.1 | Care planning culture

Within this theme, two subthemes were identified: lack of knowledge regarding ACP and AHD usefulness.

3.1.1 | Lack of knowledge regarding advance care planning

The participants described their knowledge regarding ACP and that of their work colleagues as insufficient. They reported that they not only did not deal with it on an everyday professional basis

TABLE 3 Themes and Subthemes

Themes	Subthemes	Code frequency
1. Care planning culture	1.1 Lack of knowledge regarding care planning	23.6% (38)
	1.2 AHD usefulness	18.0% (29)
2. Barriers for the practical management of AHDs	2.1 Empowerment fallacy: latent paternalism	11.1% (18)
	2.2 Paradoxical view of the role families play	6.8% (11)
	2.3 Stigma	0.6% (1)
	2.4 Use of coercive measures as a first option	8.8% (14)
3. Healthcare professional needs to implement AHDs	3.1 Developing professional competencies	6.8% (11)
	3.2 Necessary resources	5.0% (8)
	3.3 Determining the who, what, where and when of addressing AHDs	19.3% (31)

Abbreviation: AHDs, advance healthcare directives.

but, as citizens, also were unaware of it. They also revealed concerns about being insufficiently trained regarding AHDs. One interviewee commented:

> I have heard of it, but I have never seen the form, I don't know what is needed, where to go to fill one in, or whether it must be done before a notary. I'm quite unsure
>
> (E04).
>
> I would be less worried about doing it if I had information on what it is and how to do it
>
> (E05).

Those who knew of ACP were unaware of its applicability in mental health settings and tended to relate it to oncological or neurodegenerative processes, end-of-life decision-making or declaring oneself an organ donor:

> I had always thought that it had to do with matters like euthanasia or legal issues like inheritance, but I didn't know it was applicable to mental illness
>
> (E11).

The interviewees stated that no patient had ever consulted with them regarding ACP, also attributing this to a lack of knowledge: "It´s a health education issue" (E07); "Everyone is uninformed, not just the mental health patients" (E06).

3.1.2 | AHD usefulness

The participants highlighted the importance of AHD in mental health. One interviewee stated: "It's a fundamental part of peoples'

rehabilitation process" (E07) and another added: "It is beneficial for the patient" (E04).

Those interviewed considered leaving written instructions regarding treatment preferences an important opportunity for people with mental illness, in the case of hospitalization or temporarily incapacitating events because, among other possibilities, it may help avoid conflicts for family members and professionals. "AHDs would be useful for users with family conflicts and those with heightened insight because they might thereby take greater control over their own lives" (E10).

3.2 | Barriers for the practical management of AHDs

This theme included three subthemes: (a) empowerment fallacy: latent paternalism; (b) stigma; and (c) use of coercive measures as a first option.

3.2.1 | Empowerment fallacy: latent paternalism

The participants reported their concerns regarding the incorporation of AHDs into their everyday clinical practice.

They felt that maintaining a paternalistic model would prove more comfortable and make performing their job easier: "It's simpler to do as you always do, rather than looking for alternatives, not to dispute it and leave it to the professionalism of the professionals" (E01).

The interviewees questioned where the limit would lie between user autonomy and/or auto-determination, versus professional decisions, particularly when referring to crisis interventions. Some participants postulated that mental healthcare professionals should assume the responsibility of deciding on the therapeutic plan because "yielding" such decision-making power may be inconvenient: "There are situations which can become complicated to manage with an AHD, for example, if they don't wish to go to the hospital, or to be admitted or restrained" (E08); "If the incoming patient is aggressive, medication should be given; as a medical authority, you know what's in their best interests" (E11).

Others explained that cases requiring involuntary admission or the resolution of legal conflicts with users, in which the AHD is contrary to professional opinion, should be referred to the on-duty judge:

> This places us in the dilemma having to turn to judges even more. If we can't administer the appropriate medication, what do we do? A judge would have to be consulted: do you authorize me to give them such-and-such a drug? We need to be legally covered
>
> (E09).

Other participants favoured a change to the existing model: "Change is possible, greater importance should be given to individuals so that they might participate in decisions and their preferences be taken into account." (E03).

3.2.2 | Paradoxical view of the role families play

The participants revealed three types of family carers: (a) families involved in rehabilitation and decision-making processes in which the patient is essentially independent: "The family that gets involved, gives support and is present" (E05); (b) families that defer all the responsibility onto healthcare professionals, whereby the patient depends on good professional practice: "they ignore each other completely" (E04), "they are very much unconcerned" (E01); and (c) overprotective families that hinder the patient's autonomy out of fear "overprotective and placing little trust in the patient's criteria" (E08).

Despite the courage of families facing chronic illness, regarding those who are overprotective, demanding or contrary to advance planning, the interviewees considered that "when someone is unwell, the family's opinion has a large influence" (E03), yet "one should deal directly with the patient" (E05).

3.2.3 | Stigma

The issue of stigma related to the professional healthcare practice arose during the interviews. As just one participant explained, negative attitudes were present, not only in mental healthcare professionals but also in other specialties such as emergency staff:

> Stigma does exist in healthcare workers, in fact, there are complaints in emergency services: "on top of all the work we have, we have to attend to psychiatric patients", as if they weren't people like everyone else! What's that all about? It's discrimination. They don't know how to manage them because they are afraid of them, they are lacking in strategies and they ignore them, [...] The truth is they don't treat them properly, not in the slightest
>
> (E08).

3.2.4 | Use of coercive measures as a first option

The interviewees were aware of the repulsion coercive measures produced in people-in-care:

> when they are admitted to hospital, they will receive treatments they are not going to like. They say: "I was tied down or given such-and-such a treatment, I don't want to be admitted like that, without being allowed any visits or to go for a smoke."
>
> (E03).

Nonetheless, the mental healthcare professionals justified these measures: "all patients are against being restrained, yet when their health is in danger, not the staff's health but the patient's, restraint

avoids greater harm" (E10). The same interviewee went on to explain that physical restraint measures should be included in AHDs: "I'm restraining you but I'm with you, it's not a punishment."

3.3 | Healthcare professional needs to implement AHDs

Within this theme, three subthemes were identified: (a) developing professional competencies, (b) necessary resources and (c) determining the who, what, where and when of addressing AHDs.

3.3.1 | Developing professional competencies

The interviewees expressed the need to work on their communication skills and therapeutic relationships in crisis intervention situations: "there is a need for training and skills acquisition in the management of such situations, in order to have options" (E01); "for example simulations" (E11). Among the skills most highlighted by mental healthcare professionals were verbal de-escalation and maintaining an empathetic and assertive communication: "There are professionals who master that, like nursing assistants and security staff who calm them down by speaking with them, they know how to manage them" (E08).

The participants associated greater levels of skill and ability with more successful clinical results: "users that have experienced mechanical restraint claim that according to the healthcare worker's skills, similar situations would either end in mechanical restraint, or not" (E01).

3.3.2 | Necessary resources

According to the interviewees, if AHDs were a reality in daily practice, they would have difficulties honouring one of the most common requests: not being mechanically or pharmacologically restrained.

Several participants considered that, to reduce restrictive practices, individual and organizational changes would be required. The individual changes reported were to improve knowledge and attitudes to reduce negative attitudes towards mental health users and to improve their non-technical skills (as seen in the previous subthemes). Among the organizational changes requested worthy of note was the allocation of more clinical assistance time to persons-in-care: "time for the patient to be able to express what they want or don't want" (E02).

Likewise, they felt that changes in current hospital infrastructure would be necessary—for example, an increase in staffing ["with more staff, we wouldn't keep up the use of coercive strategies" (E09)] or a de-escalation room in the emergency department and/or PHU because AHDs must be respected in all healthcare contexts ["in their interests, not to seclude them. They might be more relaxed; and not just for psychiatric patients but anyone needing such a room" (E08)].

3.3.3 | Determining the who, what, where and when of addressing AHDs

The participants reflected on which medical or care matters patients should decide on "in terms of visits, meals, timetables, rules, but not treatments" (E09). Others advocated for "deciding whose care you are to be under or what devices you can use" (E01).

The healthcare professionals highlighted that whoever is to lead the care planning process with the mental health service user, they must be a known and respected provider: "it must be someone with whom they have a solid therapeutic relationship" (E07)—for example, "it should be the psychiatrist" (E02). However, one psychiatrist assigned the responsibility of informing persons-in-care to healthcare institutions: "AHDs are a matter of health education for the general public, therefore such information should be provided by healthcare institutions, not healthcare workers" (E07). Notwithstanding, most felt it was a matter of teamwork: "all those involved in interventions could contribute" (E03).

The healthcare resources identified by the interviewees as the most appropriate to inform and support mental health users regarding AHDs were the MHU: "because that's where they follow them up and they can record events in their clinical notes" (E03). There was consensus in that the PHU was not the appropriate place: "no, not here (PHU). I would suggest it be done through associations for users and users' families" (E07).

Finally, the participants asserted that verbal or written declarations of patient-in-care preferences should be encouraged during times of psychological stability: "not when conditioned or emotionally labile" (E04); "if it is performed at a time of stability, when they display the ability to reason, awareness of their illness and willingness to participate" (E11).

4 | DISCUSSION

Many revealing observations were uncovered concerning the viewpoint of Spanish mental healthcare professionals towards implementing AHD in their clinical practice setting.

Three main themes were identified describing situations that arose frequently during the interviews: care planning culture, barriers for the practical management of AHDs and healthcare professional needs to implement AHDs.

The idea that users could be involved in their care process is gaining credence worldwide. Building the care process around a person's own will and preferences towards their mental health experience seems an obvious conclusion at which to arrive (Barker & Buchanan-Barker, 2010). Care planning requires healthcare professionals and persons-in-care to collaborate on reaching preferred goals, sharing information and agreeing when to review progress (Coffey, Hannigan, & Simpson, 2017), from admission to discharge. The care process continuum emphasizes the need to focus on the user, rather than merely the setting in which it is delivered, whether the person's care needs are "critical," "transitional" or "developmental" (Barker, 2011; Barker & Buchanan-Barker, 2010). Nonetheless,

according to the present findings, Spanish mental healthcare professionals are not yet prepared.

First, a noteworthy lack of knowledge exists regarding the documentation and conversation process, on behalf of both citizens and healthcare professionals. Those who knew of ACP were unaware of its applicability in the mental health setting. The implementation of the ACP process was not identified in our findings, and none of the study participants showed a proactive attitude to implement the legal rights of persons-in-care. The completion of legal documents is necessary to ensure that the medical care provided is in line with users' preferences. Obtaining such documentation is a necessary process that takes time, through conversations with clinicians, families and/or surrogate decision makers. Conversations should be documented in medical records to provide context regarding patient decisions. Internationally, laws vary concerning the use of verbal advance directives (Sudore et al., 2017).

Mental healthcare professionals highlighted the usefulness of AHDs in cases such as hospitalization, coercive intervention and conflicts with family members. However, despite their usefulness, varying according to circumstances, the information included in AHDs strengthens healthcare assistance and protects patient autonomy (Srebnik et al., 2005).

Second, the main barrier detected regarding practical concerns surrounding AHD management in terms of decision-making was the prevailing paternalistic provider–user relationship (Alemany, 2011; Slade, 2017). Implementing AHD in routine mental health services seems to be a cultural and technical problem. The current recovery-oriented emphasis of mental health models has motivated users and providers to promote user choice, community participation and holistic well-being (Siantz, Henwood, McGovern, Greene, & Gilme, 2018). However, in line with our findings, this model is often hampered by limited resources, knowledge and attitudes producing a significant gap between the realities observed in practice and ambitions of mental health policies (Coffey et al., 2017). The implementation of AHDs in the Spanish mental health system would require macro- and micro-changes, whereby the organization/mental healthcare professionals would relinquish their paternalistic approach and embrace new ways of relating to users. Some healthcare relationship proposals are as follows: (a) "shared relationships," whereby users would participate, implying the rationalization of evidence-based information regarding options and results, together with decision-making support and a system to register and implement preferences (Slade, 2017); or (b) "patient-driven relationships," whereby the user would assume a completely active role (Coulter & Collins, 2011). For example, if a user were to reject treatments considered clinically effective, because of AHD documentation, the healthcare professionals would have the moral obligation to observe their preferences, being ensured the decision was thoroughly pondered and made with full awareness (due to ACP), thereby balancing the healthcare professional–patient relationship (Ramos Pozón & Román Maestre, 2014).

Within the aforementioned proposals on healthcare relationships, the inclusion of family carers is a necessary part of the user-empowering process. Nevertheless, their roles must be considered. The present study's qualitative data revealed three types of family carers: (a) families involved in rehabilitation and decision-making processes in which the patient is essentially independent, (b) families that defer all the responsibility to mental healthcare professionals, whereby the patient depends on good professional practice, and (c) overprotective families that hinder the patient's autonomy for fear of past experiences reoccurring, or new ones arising, that they will not know how to manage (Yanos, Vayshenker, DeLuca, & O'Connor, 2017). The paradoxical concerns of professionals regarding the participation of the latter group of families when registering AHDs are based on the evidence that patient rights are not always guaranteed due to the attitude of family carers (Parveen, Morrison, & Robinson, 2013). The stigma underlying such dispositions is known as associative stigma and can appear in professionals as well (Park & Seo, 2016), thus augmenting barriers to AHD implementation.

Third, providers sense that no suitable moment exists to prioritize AHDs. Among the main reason participants used to justify their position were (a) their poor communication skills, (b) their mental health service was not the best place for it, (c) they felt they lacked the authority, (d) they were unfamiliar with the documentation and (e) it did not fall within their job description.

On the one hand, to improve providers' poor levels of knowledge and communication skills, educational AHD projects offering training via simulation in communication, non-technical skills and the latest developments in basic bioethics should be implemented. On the other hand, according to the available evidence, decision-making and AHDs could be considered coordinated with interdisciplinary tasks requiring involvement from nurses, doctors, social workers and other healthcare staff. Mental health professionals should participate according to appropriate criteria to inform, educate, refer, write, complete and implement AHD. Nurses are ethically (morally), professionally and legally accountable for their actions (Wilson, Woollands, & Barrett, 2018). Given their key position as therapeutic agents and as part of the care team, nurses might work within interdisciplinary teams and support user decision-making and ACP processes (Gieselmann et al., 2018).

Finally, according to the present findings, the ideal mental health service for supporting users to formulate AHDs is the MHU because they frequently experience more extensive follow-ups, have greater confidence in such units and their healthcare plan can be recorded in their clinical notes. The role of PHUs in the AHD context was controversial. As the Tidal Model assumes, the primary purpose of acute care settings is to enable persons to return to the community, as quickly as possible, by helping them to cope better with the problems of living that made admission necessary (Barker & Buchanan-Barker, 2010). According to our findings, users in acute care settings only completed AHDs on discharge.

4.1 | Limitations

These data reported a wide variety of experiences of a small sample of mental healthcare professionals from the province of Alicante.

Despite statistical sampling methods not being required for qualitative research, the present study findings are bolstered by having reached data saturation. Geographical restrictions should be addressed in future studies via similar approaches in other areas of Spain, especially given the decentralized nature of the Spanish public healthcare system. Finally, our findings generated potential challenges, and it would be interesting to interview providers who may have implemented the use of AHD with mental health users.

5 | CONCLUSIONS

A better understanding of the attitudes of Spanish mental healthcare professionals towards AHDs was achieved. Respect for peoples' preferences should be systematically integrated into mental healthcare services. However, mental healthcare professionals have difficulty relinquishing paternalistic occupational habits. The interviewees identified practical barriers that need to be addressed: a gap in knowledge regarding AHDs and a lack of communication and nontechnical skills to further honour the will and preferences of patients in care. Specific training programmes are required to cover these needs and enable ACP and AHDs to be implemented at a future stage. Such training should involve users and their family members, thereby falling in line with United Nations requirements.

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